# TREATMENT PROGRESS REPORT

***Confidential***

| **State of California** |
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| **Treatment Progress Report** |
| VCGCB-VOC-6020 (Rev. 03-15-04) |

**California Victim Compensation and Government Claims Board**

Return Form To:

**Victim Compensation Program**
**P.O. Box 3036**
**Sacramento, CA 95812-3036**

Or Your Local Victim/Witness Assistance Center Verification Unit

| **Claim #** | **Date Form Sent** |
|---|---|
| **Victim's Name** | |
| **Claimant's Name** | |
| **Incident Date** | |

**The Victim Compensation Program (Program) has received your bill for mental health services. In order for the Program to verify the claimed loss, please complete this form and return it to the address above. Please answer questions fully and complete the signature page at the end of the document. Use additional pages if necessary. Failure to complete this form may result in a delay or denial of payment.**

In order for the Program to pay for services, we must verify that your client's treatment continues to be necessary as a result of the crime and is the best aid for the victim. Therefore, until this Treatment Progress Report is approved, the Program can reimburse you for no more than the initial 15 sessions of outpatient mental health services provided to this client. Additional information may be needed to verify eligibility for reimbursement, which may include session notes. **No additional payments may be authorized beyond the initial 15 sessions until a completed Treatment Progress Report has been submitted to and approved by the Program.**

If approved, this Treatment Progress Report may cover only the number of sessions remaining to reach the initial service limitation. See the chart below to determine your client's initial service limitation.

Any treatment beyond the service limitations requires the treating therapist to complete and submit an Additional Treatment Plan. Without submitting an Additional Treatment Plan and receiving Program approval, no treatment beyond 30 sessions for adults or 40 sessions for minors will be reimbursed. Consideration for approval of additional treatment involves a comprehensive review of: the crime circumstances, clear evidence that the treatment is the best aid for the victim, and, for direct victims, a careful review of the severity of the client's impairment.

**Mental Health Benefit Service Limitations:**

| **40 Sessions:** | **30 Sessions:** |
|---|---|
| Direct Victim (Minor) | Direct Victim (Adult); or<br>Direct Victim of Unlawful Sexual Intercourse (violation of PC § 261.5(d)); or<br>Derivative: Qualified Surviving Family Member of Homicide Victim or fiancé (fiancée) of homicide victim who witnessed the crime; or<br>Derivative: Eligible primary caretaker (Shared) |

**Session Calculation:**

| Individual/Family: 1 Session Hour = 1 Session | Group: 1 Session Hour = .5 (1/2) Session |
|---|---|

As required by law, the information requested by the Program, must be returned to the Board **within ten (10) business days** and must be provided at no cost to the client, the Board, or local Victim/Witness Assistance Centers. The Program certifies that there is a signed authorization on file for the release of the information requested.

You must complete this form to request reimbursement for sessions 16 through 30 (adults) or 40 (minors)
Complete all questions unless otherwise specified.

| 1. Name of Client | 2. Name of Victim |
|---|---|



Date Completed: _____

3. Client's Relationship to Victim:

4. Name of Therapist

5. Provider Organization Name

6. License/Registration Number and Expiration Date

7. Mark Appropriate Box for Title of Licensed/Registered Therapist (refer to #6)

- ☐ LMFT
- ☐ LCSW
- ☐ Licensed Clinical Psychologist
- ☐ Licensed Psychiatrist
- ☐ Psychological Assistant Intern
- ☐ LMFT Intern
- ☐ ASW
- ☐ Registered Psychologist
- ☐ Resident in Psychiatry
- ☐ Other (Please specify):

8. Name and Title of Supervising Therapist (If applicable)

9. License Number

10. Expiration Date

11. Is there substantial progress toward meeting the treatment goals?

- ☐ Yes (continue to question #12)
- ☐ No (continue to question #13)

12. If yes, do you expect that treatment will be completed within the allocated 30 sessions for adults or 40 sessions for children?

- ☐ Yes
- ☐ No (continue to question #13)

13. What complicating or confounding issues are hindering progress?

**DECLARATION**

CLIENT NAME: _____ CLAIM NUMBER: _____

If the client's offender is convicted, the Board will request the criminal court to order the offender to pay restitution to reimburse the Board for any expenses the Board has paid for the victim. The treating therapist must be prepared to testify in a restitution hearing that all mental health counseling services you provided were necessary at the percent indicated below as a direct result of the crime.

A. In your opinion, what percentage of your treatment is necessary as a direct result of the qualifying crime?

☐ 0% ☐ 75%
☐ 25% ☐ 100%
☐ 50% ☐ Other _____%

B. What type of crime is the client being treated for?

Assault With a Deadly Weapon ☐ Domestic Violence ☐ Child Abuse/Molest ☐ Sexual Assault ☐ Robbery ☐ Hit and Run ☐

Driving Under the Influence ☐ Homicide ☐ Other (Do not include any confidential facts in your description of the crime.) ☐ _____

I declare under penalty of perjury under the laws of the State of California (Penal Code sections 72, 118, and 129) that: (1) I have read all of the questions contained on this form and, to the best of my information and belief, all my answers are true, correct and complete; and (2) all treatment submitted for reimbursement by the Board or pursuant to this form was necessary at the percentage noted above and as a direct result of the crime described above. I further understand that if I have provided any information that is false, intentionally incomplete or misleading, I may be found liable under Government Code section 12650 for filing a false claim with the State of California and/or guilty of a misdemeanor or felony, punishable by six months or more in the county jail, up to four years in state prison, and/or fines up to ten thousand dollars ($10,000).

**I understand that mental health counseling treatment is approved in advance. Approval for reimbursement is for no more than those sessions allowed for this claimant (30 for adults or 40 for children). Treatment beyond that number of sessions will not be reimbursed until approved. I understand that if treatment is provided without the required approval, the Program may not reimburse those expenses.**

**IMPORTANT** – Required signature(s) below **MUST** be provided

**Treating Therapist**:

Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

**If Registered Intern**:

Supervising Therapist's Name: _____ Lic #: _____
(Please Print Clearly)

Signature: _____ Date: _____

**Tax Identification Number** of person or organization in whose name payment is to be made:

_____

Clear Form



Print